Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

- The provision of a separate section for disorders that are usually first diagnosed in infancy, childhood, or adolescence is for convenience only and is not meant to suggest that there is any clear distinction between “childhood” and adult disorders.
- Many disorders included in other sections of the manual often have an onset during childhood or adolescence.
- In evaluating an infant, child, or adolescent, the clinician should consider the diagnoses included in this section but also should refer to the disorders described elsewhere in this manual

DSM-IV TR 2000, Disorders usually first diagnosed in infancy, childhood, or adolescence

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (cont)

- For most (but not all) DSM-IV disorders, a single criteria set is provided that applies to children, adolescents, and adults (e.g., if a child or adolescent has symptoms that meet the criteria for Major Depressive Disorder, this diagnosis should be given, regardless of the individual's age).
- The variations in the presentation of a disorder that are attributable to an individual's developmental stage are described in a section in the text titled "Specific Culture, Age, and Gender Features."

DSM-IV TR 2000, Disorders usually first diagnosed in infancy, childhood, or Adolescence

Assessing Children and Youth

Reliability of Childhood Diagnoses

Developmental Issues

Manifestation of Symptoms in Children and Youth

Pre-Morbid States in Childhood and Adolescence

Conduct Disorder

It is the most prevalent diagnosis among delinquent youth but rarely presents alone. High rate of co-morbidity with other diagnoses such as depressive disorders, ADHD, learning disorders.

One of the most divisive issues in working with children/youth, it can often be an exclusion to services.

Pitfalls in Diagnosing Conduct Disorder

Clinicians stop diagnostic process with this diagnosis

"Only when behavior is symptomatic of an underlying dysfunction within the individual…not a reaction to the immediate social context" – DSM-IV

Conduct Disorder is not a precursor to Antisocial Personality Disorder

Majority of youth with conduct disorder "remit by adulthood"

Communication Disorders

- Expressive Language Disorder – more common in males than females, school age prevalence 3-7%

- Mixed Receptive-Expressive Language Disorder – school age prevalence 3%

Autism Spectrum Disorders

- Autism – impairments in social interaction, language and restricted repertoire of activities/interests present prior to the age of three
  - Associated behavioral symptoms – hyperactivity, short attention span, impulsivity, aggressiveness, self-injurious behaviors, temper tantrums
  - Excluded diagnoses – Asperger's Disorder and ADHD

Asperger's Disorder

- Severe and sustained impairment in social interaction and development of restricted, repetitive patterns of interests/activities
- No clinically significant delays in language or early cognitive development
- Often first diagnosed with ADHD, frequent Depressive Disorder
- Differential Diagnosis – Schizoid Personality Dx

Attention Deficit Hyperactivity Disorder

- Some symptoms present prior to age of 7 years
- Present in at least two settings
- Symptoms may lessen in novel situations, one on one, with behavioral contingencies
- Higher rate of co-occurring Disruptive Behavior

Oppositional Defiant Disorder

- Prior to puberty Males>females, equal rate after puberty
- Onset typically prior to 8 y/o, no later than early adolescence
- Higher rate with depressed mothers and in homes with serious marital discord
- Do not diagnosis if qualifies for Conduct Disorder
- Look for communication disorders

Depressive Episodes

In children and adolescents mood may be irritable rather than sad

In children, failure to make expected weight gains

Dysthymia – mood disturbance is 1 year for children/adolescents

Depressive Episodes

- Somatic complaints, irritability, and social withdrawal are particularly common in children.
- Psychomotor retardation, hypersomnia, and delusions are less common in prepuberty than in adolescence.

DSM-IV TR 2000, Mood Disorders, Page 354

Depressive Episodes (cont)

- In prepubertal children, Major Depressive Episodes occur more frequently in conjunction with other mental disorders (especially Disruptive Behavior Disorders, Attention-Deficit Disorders, and Anxiety Disorders) than in isolation.
- In adolescents, Major Depressive Episodes are frequently associated with Disruptive Behavior Disorders, Attention-Deficit Disorders, Anxiety disorders, Substance-Related disorders, and Eating Disorders.

DSM-IV TR 2000, Mood Disorders, Page 354

Manic Episodes

Differential Diagnosis ADHD

- ADHD onset prior to age 7 years
- ADHD Chronic rather than episodic
- Absence of expansive or elevated mood
- Absence of psychotic features
- Disruptive Sleep vs decreased sleep
- ADHD lack of hypersexuality

Manic Episodes

- Manic Episodes in adolescents are more likely to include psychotic features and may be associated with school truancy, antisocial behavior, school failure, or substance use.
- A significant minority of adolescents appear to have a history of long-standing behavior problems that precede the onset of a frank Manic Episode.

DSM-IV TR 2000, Mood Disorders, Page 360

Bipolar Disorders

Children much more likely to present with severe rapid-cycling (also adolescents)

More likely to be diagnosed with Bipolar II Disorder due to brevity of manic episodes

High rate of co-morbidity (or premorbid) with ADHD, Conduct Disorder and substance abuse

Posttraumatic Stress Disorder

In children, their response to the traumatic event may be more characterized by disorganized or agitated behavior as opposed to fear, helplessness or horror

For children, the traumatic event can be developmentally inappropriate sexual experiences without threat of harm or injury

PTSD

- Distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others.
- Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars).

DSM-IV TR 2000, Anxiety Disorders, Page 466

PTSD (cont)

- Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers.
- In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult.

DSM-IV TR 2000, Anxiety Disorders, Page 466

PTSD (cont)

- There may also be “omen formation” – that is, belief in an ability to foresee future untoward events.
- Children may also exhibit various physical symptoms, such as stomachaches and headaches.
- Posttraumatic Stress Disorder can occur at any age, including childhood.

DSM-IV TR 2000, Anxiety Disorders, Page 466

Social Phobia

Children may not recognize that fear is excessive or unreasonable

For individuals under 18 years of age, symptoms must have occurred for 6 months or longer

Differential diagnosis with Separation Anxiety Disorder which is anxiety related to leaving home or those to whom attached, NOT social situations. (A social situation in the home would bother someone with Social Phobia but not Separation Anxiety

Social Phobia

- In children, crying, tantrums, freezing, clinging or staying close to a familiar person, and inhibited interactions to the point of mutism may be present.
- Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults.

DSM-IV Tr 2000, Social Phobia, Page 452

Social Phobia (cont)

- Unlike adults, children with Social Phobia usually do not have the option of avoiding feared situations altogether and may be unable to identify the nature of their anxiety.
- There may be a decline in classroom performance, school refusal, or avoidance of age-appropriate social activities and dating.
- To make the diagnosis in children, there must be evidence of capacity for social relationships with familiar people and the social anxiety must occur in peer settings, not just in interactions with adults.

DSM-IV TR 2000, Social Phobia, Page 453

Social Phobia (cont)

- Because of the disorder's early onset and chronic course, impairment in children tends to take the form of failure to achieve an expected level of functioning, rather than a decline from an optimal level of functioning.
- When the onset is in adolescent, the disorder may lead to decrements in social and academic performance.

DSM-IV TR 2000, Social Phobia, Page 453

Obsessive – Compulsive Disorder

- Washing, checking, and ordering rituals are particularly common in children.
- Children generally do not request help, and the symptoms may not be ego-dystonic.
- Gradual declines in schoolwork secondary to impaired ability to concentrate have been reported.
- More prone to engage in rituals at home than in front of peers, teachers, or strangers.

DSM-IV TR 2000, Obsessive-Compulsive Disorder, Page 459

Schizophrenia

- In children failure to achieve developmental milestones rather than a deterioration in functioning
- Onset prior to adolescence rare but can occur
- Delusion/hallucinations may be less elaborated and visual hallucinations more common
- Prodromal stage – Social withdrawal and isolation, disruptive behavior disorders, academic difficulties, speech and language problems and developmental delays

Personality Disorders

- Personality disorder categories may be applied to children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or an episode of an Axis I disorder.
- To diagnose a Personality Disorder in an individual under age 18 years, the features must have been present for at least 1 year.

DSM-IV TR 2000, Personality Disorders, Page 687

Borderline Personality Disorder

"Pervasive pattern of instability of interpersonal relationships, self-image, affects and marked impulsivity" (DSM-IV)

Adolescence is a period of instability in relationships, identity and mood. Additionally, impulsivity and engaging in risk-taking behaviors is part of normal adolescent development

Borderline Personality Disorder

Adolescence is not typically marked by:

Fears of abandonment (independence vs dependence)

Self-image based on being bad or evil

Chronic feelings of emptiness (not boredom)

Self-injurious behavior

In assessing, compare “extremes”

With developmental level